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Supreme Court, U.S.
FILED

No. 08-0845 JUL 7 2008

IN THE OFFICE OF THE CLERK
Supreme Court of the United States

BENEFIT RECOVERY, INC.,

Petitioner,

v.

JAMES J. DONELON,
in his Official Capacity as Commissioner of Insurance
for the State of Louisiana,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Does § 1132 of ERISA preempt the Louisiana Commissioner of Insurance's Directive 175, which mandates inclusion of make-whole and attorney-fee-recovery subrogation provisions in ERISA plans delivered in Louisiana, because it is an attempt by the Commissioner to supplement the remedies available to ERISA plan beneficiaries?

2. Does § 1144(a) of ERISA preempt Directive 175 because it is a regulation having the effect of state law that relates to an ERISA plan?

3. Even if ERISA does not preempt Directive 175, can Directive 175 be valid as a federal rule of decision even if was improperly issued and incorrectly restates Louisiana subrogation law?

STATEMENT PURSUANT TO RULE 29.6

Petitioner Benefit Recovery, Inc. has no parent company, and that there is no publicly held company that owns 10% or more of its stock.

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Opinions Below

The March 11, 2008 opinion of the United States Fifth Circuit Court of Appeal is officially reported at 521 F.3d 326 (5th Cir. 2008), and is reproduced in the appendix. The Fifth Circuit's April 8, 2008 *per curiam* denial of rehearing and rehearing *en banc* is unreported and is reproduced in the appendix.

The December 6, 2006 opinion of the United States District Court for the Middle District of Louisiana and its April 11, 2007 denial of Benefit Recovery's motion to alter or amend are unreported, and are reproduced in the appendix.

Basis for Jurisdiction

The judgment of the United States Fifth Circuit Court of Appeal was entered on March 11, 2008, and the Fifth Circuit's unitary denial of rehearing and rehearing *en banc* was entered on April 8, 2008. This petition is timely under 28 U.S.C. § 2101 and Supreme Court Rules 13.1 and 13.3 because it is being filed within 90 days of entry of the order denying rehearing.

Statutory Provisions Involved

The two preemption provisions of ERISA are involved in this case. First, 29 U.S.C. § 1132 generally sets forth the scope of actions and remedies available to ERISA beneficiaries and fiduciaries, and preempts state laws purporting to provide additional actions or remedies.

Second, 29 U.S.C. § 1144(a) provides in relevant part that

> "Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title."

Statement of the Case

Benefit Recovery's Business

For the past nine years, Benefit Recovery has been one of the nation's premier subrogation vendors, specializing in obtaining the greatest subrogation recovery possible for the health benefit plans with which it contracts. Some of these plans are located in Louisiana. Typically, a Louisiana health benefit plan pays for the treatment of accidental injuries sustained by a plan member, who by contract must notify the plan of any lawsuits begun against potentially responsible persons. The plan's terms usually permit it to subrogate to the member's rights and intervene in these lawsuits up to the amount the plan has paid for the member's treatment. Benefit Recovery, in turn, contracts with the health plans to exercise their subrogation rights, which are assigned in whole or in part to Benefit Recovery. Benefit Recovery's expertise enables it to obtain greater subrogation benefits than the heath plans would otherwise be able to get, and Benefit Recovery is paid a percentage of the subrogation recovery.

Each ERISA plan providing health benefits contains its own specialized provisions, but they often provide that the plan (and its agent, Benefit Recovery) can recover in subrogation the value of all of the benefits the plan has provided to the beneficiary, from the first dollar recovered by the beneficiary; Benefit Recovery's contract with Ochsner Health Plan, for example, provides that amounts recovered "shall be applied to reimburse" Ochsner for its expenses, regardless of whether this "results in the Member's partial recovery for his damages." Similarly, many plans do not contain provisions requiring the plans to reimburse the beneficiary for the attorney's fees incurred in pursuing this kind of tort claim.

The Louisiana Commissioner of Insurance Issues Directive 175

On January 8, 2003, the Louisiana Commissioner of Insurance issued Directive 175, which ordered health insurance issuers to begin incorporating into their plans (1) a provision making their recovery subordinate to the right of the insured to be made whole, and (2) a provision making them pay a share of the costs and fees incurred by the insured in obtaining any recovery against third parties:

> While insurers are free to include whatever provisions they choose in their policies, the provisions must be consistent with the laws and public policy of Louisiana. It has long been the public policy of this state, as expressed in Louisiana jurisprudence, that subrogation provisions in insurance contracts

> cannot harm the insured. This same rule of public policy applies to reimbursement provisions in insurance contracts. Further, an insurer in invoking a subrogation or reimbursement provision is required by the public policy of this state to contribute to the attorney's fees incurred in obtaining a recovery from the third party.
>
> . . . **The Commissioner will consider for approval language that clearly conveys to the insured that any right of recovery from third parties on the part of the insurer, whether by subrogation or reimbursement, is subordinate to the insured's right to be fully compensated for his damages; and that the insurer is obligated to share in the legal expenses incurred.** The Commissioner will not approve policy language that excludes and/or reduces coverage for expenses incurred as a result of the treatment of injury or sickness caused by the fault of a third-party (emphasis added).

A plan provision of the sort required by Directive 175 will radically change the way subrogation works for some plans. Benefit Recovery will no longer be able to obtain full reimbursement for amounts advanced by the plans. Rather, Benefit Recovery is subrogated to the amounts received only after the beneficiary has been fully compensated — and, if the amount paid in settlement is less than the general and nonmedical damages sustained by the beneficiary, under Directive 175 the beneficiary can keep the entire amount paid in settlement or

judgment. Further, even if the beneficiary were to obtain a settlement or judgment in excess of his or her loss, Benefit Recovery can only recover a portion of the benefits it provided if (1) the settlement or judgment is greater than the beneficiary's nonmedical damages, ***and*** (2) if that happens, Benefit Recovery must share in the attorney's fees incurred by the beneficiary in obtaining a recovery.

After the Commissioner promulgated Directive 175, it rejected proposed health insurance coverage forms from Ochsner Health Plan — a company that contracted with Benefit Recovery — as well as several other large health plans because the forms did not comply with Directive 175. By law, these health insurers are prohibited from using any form in Louisiana that is not approved by the Commissioner, and Directive 175 itself warned that insurers who certified compliance and later used a prohibited form "will be subject to sanctions including but not limited to the imposition of such fines as are authorized by law."

Procedural History in the Courts Below

Benefit Recovery filed suit in the United States District Court for the Middle District of Louisiana, seeking (1) a declaratory judgment that ERISA's conflict preemption and complete preemption provisions (29 U.S.C. §§ 1132 and 1144(a)) displaced Directive 175, at least insofar as it applied to ERISA health benefit plans; and (2) an injunction against further enforcement of this directive to ERISA plans. Benefit Recovery further alleged that Directive 175 was invalid because

it was improperly promulgated and did not correctly reflect state law. Federal jurisdiction existed over Benefit Recovery's claims under 28 U.S.C. § 1331.[1]

On April 16, 2004, the district court determined that it would not permit Benefit Recovery to question the substantive validity of Directive 175 as a matter of state law, granting the Commissioner's motion to dismiss Benefit Recovery's state claims under the Eleventh Amendment without addressing whether Directive 175 could be challenged as a suspect state law providing a federal rule of decision. Following discovery, the parties filed cross-motions for summary judgment, focusing solely on whether Directive 175 was preempted by ERISA's complete preemption provision, § 1144(a). On December 5, 2006, the district court denied Benefit Recovery's summary judgment motion and granted the Commissioner's motion. The district court applied the test announced by this Court in *Kentucky Assoc. of Health Plans, Inc. v. Miller*,[2] which held that state action falls within the ERISA preemption savings clause if (1) the action is a state law that is specifically directed toward entities engaged in insurance, and (2) the state law substantially affects the risk pooling arrangement between the insurer and the insured. First, the district court held that Directive 175 is a state law under ERISA, viewing the scope of the preemption clause and the scope of the savings clause as identical. Second, the district court found that Directive 175 affects the risk pooling arrangement between the insurer and the

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[1] *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 n. 14 (1983).

[2] 538 U.S. 329 (2003).

insured because it controlled the terms of the policies offered to beneficiaries. Finally, the district court rejected Benefit Recovery's effort to challenge the substantive underpinnings of Directive 175, basing this determination on its prior ruling that Benefit Recovery's claims under state law were barred by the Eleventh Amendment. One day later, the district court entered a final judgment dismissing Benefit Recovery's entire case, even though the parties had only submitted the issue of § 1144(a) preemption to the court in their summary judgment motions.

After the district court denied Benefit Recovery's Rule 59(e) motion to alter or amend, Benefit Recovery appealed the district court's decision to the United States Fifth Circuit Court of Appeal.[3] On March 11, 2008, the Fifth Circuit affirmed the decision of the lower court, rejecting two of Benefit Recovery's arguments on procedural grounds and one on a substantive basis. First, the Fifth Circuit held that Benefit Recovery did not preserve for appeal the issue of whether § 1132 preempted Directive 175, reasoning that Benefit Recovery did not present this issue to the lower court in its summary judgment motion and neglected to brief the assignment of error until its reply brief. Second, the court affirmed the decision of the lower court that § 1144(a) did not preempt Directive 175 under the *Miller* test. Finally, the Fifth Circuit held that Benefit Recovery raised the issue of whether Directive 175 was valid as a surrogate federal rule of decision too late, and waived this issue from consideration by the district court.

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[3] Because Benefit Recovery's appeal was timely from the district court's December 6, 2006 final judgment, the court of appeals had jurisdiction under 28 U.S.C. § 1291.

Reasons for Granting the Petition

This is an ERISA case. As lower courts have bemoaned time and time again, the provisions of ERISA are confusingly written, and the reasoning in the legal decisions interpreting the statute shift like the sands of time. But the statute is as important as it is cumbersome, and its provisions intimately affect the lives of millions of Americans.

The ERISA preemption provisions are among the most important in federal law. Without them, ERISA's promises of standardized benefits available under federal law are illusory. Yet if the lower court's decision is permitted to stand, each and every state in the union will be able to avoid ERISA preemption with ease by abdicating its legislative prerogative and simply permitting (or, indeed, mandating) its insurance commissioner to gin out regulation after regulation purporting to affect all insurance policies or ERISA plans in the state. ERISA must be safeguarded against this sort of state overreaching.

Argument

A. ERISA preempts Directive 175.

The Employee Retirement Income Security Act of 1974 is a landmark statute designed to establish predictable nationwide standards for employee benefit plans.[4] To achieve ERISA's purpose of providing a "uniform regulatory regime over employee benefit

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[4] *See generally* 29 U.S.C. § 1001(b).

plans," the statute contains two separate and independent preemption provisions. First, § 1132 provides an "integrated system of procedures for enforcement" of ERISA rights, and Congress' policy choices regarding "the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA."[5] Accordingly, § 1132 has "extraordinary" preemptive power, and completely preempts state attempts to alter or supplement the remedies it gives to plan beneficiaries.[6] Second, § 1144(a) of ERISA is a conflict preemption provision, mandating that ERISA preempts and supersedes all state laws that "relate to" employee benefit plans.

The application of ERISA's preemption provisions should be straightforward, and Benefit Recovery respectfully submits that this Court should accept certiorari to review the Fifth Circuit's erroneous decision that neither § 1132 nor § 1144(a) preempt Directive 175. Lower courts have continually lamented the fact that deciding ERISA preemption issues means a "descent into a Serbonian bog wherein judges are forced to don logical blinders and split the linguistic atom to decide even the most routine cases."[7] This case

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[5] *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987).

[6] *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 65-66 (1987).

[7] *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 454 (3d Cir. 2003) (concurrence of Judge Becker).

presents a unique opportunity to provide a bridge over that bog.

1. § 1132 preempts Directive 175 because it is an impermissible attempt by the Commissioner to provide ERISA beneficiaries with supplemental remedies against their plans based on his personal interpretation of state law.

Although the district court did not address § 1132 preemption and the Fifth Circuit refused to consider it, the governing standards for § 1132 preemption established in *Aetna Health Inc. v. Davila*[8] govern this case and demonstrate that Directive 175 is completely preempted.

a. Benefit Recovery preserved for appeal the issue of § 1132 preemption.

The Fifth Circuit avoided reaching the merits of § 1132 preemption by finding that Benefit Recovery had waived this issue on appeal. The flaw in the Fifth Circuit's reasoning lies in conflating the legal error Benefit Recovery believed the district court committed (rejecting Benefit Recovery's argument that § 1132 preempted Directive 175) with the procedural mechanism used by the district court (dismissing Benefit Recovery's § 1132 claim after the parties filed cross-motions for summary judgment addressing only § 1144(a) preemption).

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[8] 542 U.S. 200 (2004).

It is undisputed that Benefit Recovery pleaded complete preemption under § 1132 of ERISA in its original Complaint and preserved this claim in the pretrial order, pressing it to the district court. It is similarly uncontested that neither Benefit Recovery nor the Commissioner submitted the § 1132 preemption claim to the district court on summary judgment. Nevertheless, the district court's final judgment dismissed Benefit Recovery's entire case, including both the claim presented to it on summary judgment as well as the unsubmitted claim that § 1132 preempted Directive 175. Accordingly, when Benefit Recovery appealed to the Fifth Circuit, the very first issue presented for review in its original brief was whether § 1132 preempted Directive 175, and Benefit Recovery argued this point for ten pages.

Benefit Recovery did not raise the procedural mechanism used by the district court (dismissing its § 1132 preemption claim *sub silentio*) as an independent error to the Fifth Circuit. Perhaps the district court did, in fact, commit an additional error — aside from the ***substantive*** error of rejecting preemption under § 1132 of ERISA, which Benefit Recovery preserved for appeal and completely briefed, from a ***procedural*** standpoint the district court acted wrongly in dismissing Benefit Recovery's § 1132 claim because that claim was not before it on summary judgment. But regardless of whether the district court committed this additional procedural error by going beyond the scope of the summary judgment pleadings, the effect was patent: the district court dismissed Benefit Recovery's § 1132 claim on the merits. This was the legal error Benefit Recovery believes the district court committed, this was the legal

error appealed to the Fifth Circuit, and this was the legal error briefed by Benefit Recovery.[9] Accordingly, the Fifth Circuit erred in failing to reach the merits of § 1132 preemption.

b. § 1132 preempts Directive 175.

The seminal case on § 1132 preemption remains this Court's 2004 decision in *Davila*, which involved two consolidated cases arising in Texas. In one, an ERISA plan beneficiary was denied the medication of his choice, and suffered personal injuries from the substitute medication required by his plan; in the other, an ERISA plan beneficiary was denied continued coverage for a lengthy hospital stay, and sustained personal injuries when she was forced to leave the hospital prematurely.

Both beneficiaries sued their plans for allegedly violating duties imposed by the Texas Health Care Liability Act. As a result, the central question in *Davila* was whether the plaintiffs could access state law remedies established under the Texas Health Care Liability Act or whether those supplemental remedies

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[9] Indeed, it would have been inappropriate for Benefit Recovery to raise the procedural error of the district court in its original brief. At the time Benefit Recovery appealed this case, Benefit Recovery did not know that the Commissioner intended to argue that Benefit Recovery's § 1132 claim should have been submitted to the district court at the summary judgment stage, relying on the notion that the cross-motions for summary judgment were the functional equivalent of a trial. Once this procedural argument was made for the first time in the Commissioner's brief, Benefit Recovery responded in its reply brief.

were preempted by ERISA. On appeal, the Fifth Circuit held that the Texas Health Care Liability Act was not preempted because it created an "an external, statutorily imposed duty" that fell outside the scope of ERISA.

This Court reversed. The Court began its analysis by stressing that the remedies established in § 1132 are exclusive:

> The limited remedies available under ERISA are an inherent part of the "careful balancing" between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans.[10]

The Court reasoned that allowing states to provide additional remedies to ERISA plan beneficiaries would marginalize the remedial scheme established in § 1132:

> The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. The six carefully integrated civil enforcement provisions found in [§ 1132] of the statute as finally enacted provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.

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[10] *Davila*, 542 U.S. at 215.

> Therefore, **any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted.**[11]

As a result, the Court concluded that the Texas Health Care Liability Act was completely preempted by § 1132, and rejected the argument that § 1132 preemption is limited by the savings clause established in § 1144(b)(2)(A):

> ERISA [§ 1144(b)(2)(A)] must be interpreted in light of the congressional intent to create an exclusive federal remedy in ERISA [§ 1132]. Under ordinary principles of conflict pre-emption, then, **even a state law that can arguably be characterized as "regulating insurance" will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme.**[12]

The principles established in *Davila* govern this case and demonstrate that Directive 175 is preempted by § 1132 because it conflicts with ERISA's exclusive remedial scheme. The six "carefully integrated civil enforcement provisions" do not provide ERISA

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[11] *Id.* at 208-09 (emphasis added; citations omitted; italics in original).

[12] *Id.* at 217-218 (emphasis added).

beneficiaries with rights and remedies consistent with the make-whole doctrine or attorney-fee-recovery principles. This Court has made it abundantly clear that the decision whether or not to include these requirements as a matter of federal law falls within the singular power of Congress to legislate.[13] States are not free to engraft their own make-whole and attorney-fee-recovery provisions onto ERISA, nor can their insurance commissioners, through the back door, accomplish precisely the same result by ordering ERISA plans to include these provisions.

Although this Court need do no more than apply the principles established in *Davila* to determine that Directive 175 explicitly conflicts with § 1132, further support for forbidding the wholesale importation of the make-whole doctrine or an attorney-fee-recovery provision into the scope of remedies available to ERISA beneficiaries can be implied from the methodology of virtually all of the lower federal decisions that have examined ERISA subrogation. There is currently a split in the circuits about what to do if a plan is silent or ambiguous about the make-whole doctrine. Some circuits, as a matter of federal law, have held that if an ERISA plan is silent on the matter, the plan may only recover in subrogation after the insured is made whole;[14]

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[13] As the Court has stated on no less than three separate occasions, Congress "did *not* intend to authorize other remedies" in addition to § 1132 "that it simply forgot to incorporate expressly." *E.g., Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985) (italics in original).

[14] *E.g., Cagle v. Bruner*, 112 F.3d 1510, 1521 (8th Cir. 1997); *Barnes v. Independent Auto. Dealers Ass'n of California Health and Welfare Benefit Plan*, 64 F.3d 1389, 1395 (9th Cir. 1995).

others disagree.[15] But even the circuits that have applied the make-whole doctrine to ERISA plans have done so by recognizing that the make-whole doctrine is a general tenet of subrogation law that can form federal common law as a gap filler if the ERISA plan was silent.[16] What these circuits have not done is apply state subrogation law to the ERISA plans at issue. The reason is simple: in *FMC Corp. v. Holliday*,[17] this Court held that a Pennsylvania antisubrogation statute (making subrogation unavailable in actions arising out of automobile accidents) was completely preempted insofar as it applied to ERISA plans. Accordingly, federal courts have uniformly recognized that the provisions of state subrogation law should never govern the determination of whether the make-whole doctrine or related subrogation tenets may be applied to an ERISA plan.[18]

The point here is that, even if Louisiana had adopted a formal statute requiring the make-whole doctrine and the payment of a portion of the beneficiary's attorney fees, this statute would certainly not be applied in the face of contrary language in an ERISA plan, and could not even be used as a gap filler if an ERISA plan was

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[15] *Sunbeam-Oster Co., Inc. Group Benefits Plan for Salaried and Non-Bargaining Hourly Employees v. Whitehurst*, 102 F.3d 1368, 1378 (5th Cir. 1996).

[16] *E.g., Barnes*, 64 F.3d at 1395.

[17] 498 U.S. 52 (1990).

[18] *Paris v. Iron Workers Trust Fund*, 211 F.3d 1265 (4th Cir. 2000) (table; text in Westlaw); *Cagle*, 112 F.3d at 1521; *Barnes*, 64 F.3d at 1392-93.

silent or ambiguous. And if Louisiana cannot, through positive legislation, grant those remedies to ERISA plan beneficiaries, then surely the Louisiana Commissioner of Insurance cannot do so by trying to force ERISA plans to include language in the plan document itself.

In fact, unless this Court grants this Petition and reverses the court below, the structure, function, and exclusivity of the remedial scheme established in § 1132 will be severely undermined. If Directive 175 survives preemption, state legislatures across the country will be able to circumvent the scope of complete preemption with alarming ease. To avoid the specter of complete preemption, legislatures will abandon the practice of enacting statutes that provide external statutory remedies (which are clearly preempted under *Davila*), and instead simply force insurers to incorporate those remedies into the terms of their ERISA plans. This future legislation will, in essence, be insulated from § 1132 preemption by precluding the claims that typically trigger complete preemption from ever arising. After all, once the supplemental remedies are forcibly imbedded in the terms of an ERISA plan, § 1132 would arguably preserve them by enabling ERISA plan beneficiaries to enforce their rights under the plan. In that circumstance, the insurers could only challenge the legislation through the preemption clause established in § 1144(a) — which is limited, of course, by the savings clause. That result would be fundamentally inconsistent with this Court's ruling in *Davila* that "even a state law that can arguably be characterized as 'regulating insurance' will be pre-empted if it provides a separate

vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme."[19]

Directive 175's pernicious effect can be viewed in another way. In *Sereboff v. Mid Atlantic Medical Serv., Inc.*,[20] this Court held that a plan seeking contractually to recover benefits it paid to a plan beneficiary who receives a tort recovery from a third party asserts an equitable claim under § 1132. In effect, then, apart from supplementing the remedies available to an ERISA beneficiary, Directive 175 impermissibly supplants the equitable remedies ERISA plans themselves would have to recover the full extent of their payments by limiting their contractual subrogation rights.

In *FMC* this Court aptly identified the danger to Congress' intent in passing ERISA if state subrogation provisions were permitted to apply to ERISA plans, and noted that "to require plan providers to design their programs in an environment of different state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits."[21] The very same concern is present in this case. If the Fifth Circuit's failure to find Directive 175 preempted is allowed to stand, the integrity of ERISA's remedial scheme will be jeopardized and ERISA plans will be placed in the same morass they would have been had

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[19] *Davila*, 542 U.S. at 217-218.

[20] 547 U.S. 346 (2006).

[21] *FMC Corp.*, 498 U.S. at 408-09.

the Pennsylvania antisubrogation statute been upheld. This is precisely what Congress sought to avoid when enacting ERISA.

2. § 1144(a) preempts Directive 175, a "State law" that "relate[s] to an employee benefit plan."

§ 1144(a) mandates that ERISA shall "supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." The Fifth Circuit correctly found that Directive 175 falls squarely within this provision, but erred in finding that it also fell within the clause saving insurance statutes from § 1144(a)'s preemptive effect.

a. Directive 175 is a state law that relates to an employee benefit plan for purposes of § 1144(a).

§ 1144(a) provides that all "State law[s]" that "relate" to an ERISA plan are preempted. Initially, the Fifth Circuit correctly held that Directive 175 is a "State law" under this provision. "State law" is defined in § 1144(c)(1), which provides that it "includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State." Accordingly, because Directive 175 has the effect of law, there is no need to engage in a "metaphysical inquiry into the nature of 'law'" (in the words of the Fifth Circuit) in order to find that Directive 175 falls within the scope of § 1144(a). The Louisiana Insurance Code recognizes that if a company violates one of the Commissioner's directives, it is subject to monetary penalties just as if

it violated any other provision of state law,[22] and the "hand of the state firmly, though not harshly, requires compliance" with Commissioner directives, making them have the effect of law. The Fifth Circuit was also correct in holding that Directive 175 "relate[d] to an employee benefit plan." In *FMC* this Court held, in no uncertain terms, that a state antisubrogation provision related to an employee benefit plan.[23]

b. Directive 175 does not fall within § 1144's savings clause.

1) Directive 175 is not a "law of any State."

Although the Fifth Circuit concluded that Directive 175 fell within § 1144(a), it erred in holding that Directive 175 is saved from preemption under the savings clause, § 1144(b)(2)(A).

First, the Fifth Circuit failed to recognize that the scope of the savings clause is not nearly as broad as the scope of the preemption clause. Although the savings clause was designed to ensure that states could retain some authority over the regulation of insurance, banking and securities, Congress did not employ the same sweeping definition of "State law" to govern its application. Rather, the savings clause provides that:

> Except as provided in [the deemer clause] nothing in this subchapter shall be construed

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[22] LSA-R.S. 22:1316 A.

[23] *FMC Corp.*, 498 U.S. at 408-09.

> to exempt or relieve any person from **any law of any State** which regulates insurance, banking, or securities."[24]

There is a fundamental, albeit subtle, distinction between the phrase "any law of any State" used in the savings clause and the term "State law" used in the substantive provision. As noted above, "State law" is a term of art which is explicitly — and expansively— defined in § 1144(c)(1). When Congress defined the scope of the preemption clause, it went out of its way to ensure that ERISA would preempt not only "law," as the term is traditionally defined, but also "any State action having the effect of law." Given that ERISA is "a comprehensive and reticulated statute, the product of a decade of congressional study of the Nation's private employee benefit system,"[25] Congress' decision not to extend the savings clause to all "State law" cannot be viewed as a simple oversight.

But Congress explicitly limited the application of the savings clause to "law" regulating insurance, banking, or securities. Because the word "law" was used in the savings clause outside of the statutorily defined term "State law," the rules of statutory construction require this Court to interpret the word according to its plain

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[24] 29 U.S.C. § 1144(b)(2)(A) (emphasis added). The deemer clause is not implicated in this action because Directive 175 is not applicable to self-funded health plans.

[25] *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 209 (2002).

meaning.[26] When the savings clause is read in that context, it becomes unmistakably clear that Directive 175 is not saved from preemption. As a result, Directive 175 is preempted by § 1144(a).

The Fifth Circuit came very close to accepting this argument, damning it with faint praise by finding that it was a "not-absurd proposition" that may have "intuitive merits." The reason the Fifth Circuit ultimately rejected it is less clear:

> **We conclude that any "State law" as defined in the preemption provision qualifies as the "law of any State" for the purposes of the savings clause.** The savings clause was phrased with "similar breadth" as the preemption clause. The Court observed this in the process of holding that a judicially created notice-prejudice rule regulated insurance and therefore was saved from preemption. **If a judicial rule can be a state law, it is far from certain where we would draw the dividing line between "State laws" and "laws of any State."** Given the similar breadth of the clauses, if statutes and state supreme court decisions are State laws, it follows that rules, regulations, and anything else having the effect of law are as well (emphasis added)

But every judicial decision must make distinctions and draw dividing lines between what is acceptable and what

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[26] *Robinson v. Shell Oil Co.*, 519 U.S. 337, 340 (1997).

is not; this is the nature of our system of justice. And this case presents a signal opportunity for this court to draw the very line the Fifth Circuit refused to craft. Benefit Recovery suggests that a logical dividing line is this: the "laws of any State" that are saved are those statutes and regulations that are properly promulgated under the relevant state's laws. After all, the very purpose of the savings clause is to protect laws of general applicability passed by state legislatures that wish to regulate insurance. On the other hand, if a state insurance commissioner decides on his or her own volition to interpret the state's insurance law in an idiosyncratic or unsupported fashion, there is no reason that determination should be saved from preemption.

This reading of the savings clause is consistent with the legislative history of ERISA, which is a key consideration.[27] As noted above, ERISA's preemption clause was designed to insulate ERISA plans from a multiplicity of state legislative enactments. Accordingly, Congress chose deliberately expansive language, recognizing in § 1144's definitional section that state actions might affect ERISA plans even if the actions didn't fall within the traditional understanding of what was a law. By contrast, the savings provision recognized that state insurance laws of general applicability probably would not harm the intent of Congress in creating a uniform statute; a second undercurrent of the ERISA savings clause is a concern for federalism — Congress did not want to dictate to states the manner in which they legislated insurance. But this concern is absent when a regulation issued by a state insurance

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[27] *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 204 (1985).

commissioner without proper statutory foundation is at issue. These regulations are the product of one person who, albeit elected, does not speak for the state.[28]

As the Fifth Circuit recognized, the § 1144(b)(2)(A) savings provision is designed to be ***narrowly*** read.[29] It would not be consistent with the narrow scope of the savings clause to read its phrase "law of any State" in the same way the phrase "State law" is used in the ***expansive*** preemption clauses. The purpose of the preemption clause was to prevent anything having the effect of law from affecting an ERISA plan. The purpose of the savings clause was to carve out a limited exception for state insurance laws.

2) Even if it were a "law of any State," Directive 175 is not saved from ERISA preemption because it fails the *Miller* test.

In *Kentucky Ass'n of Health Plans, Inc. v. Miller*,[30] this Court held that in order for a state law to be one

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[28] Notably, here the Commissioner's stated substantive underpinnings for Directive 175 find their origins only in state laws of general application, not those relating to the insurance industry. Completion of the savings clause analysis requires delving into the underlying basis for the Commissioner's Directive and this obligation cannot be avoided by suggesting that this is an issue of state law as to which the Commissioner enjoys immunity from federal attack.

[29] *Pilot Life*, 481 U.S. at 46 (citations omitted).

[30] 538 U.S. 329 (2003).

which "regulates insurance" under the savings clause, it must (1) "be specifically directed toward entities engaged in insurance," and (2) "substantially affect the risk pooling arrangement between the insurer and the insured."[31] The Fifth Circuit found that both prongs of this test were met, determining that Directive 175 affected risk pooling because it affected the terms of the insurance policies to which it applied:

> Benefit argues that the "risk pooling" at issue is different from that identified in *Miller*, in which the Court determined that an "any willing provider" requirement, which prevented discrimination against any provider willing to meet the terms and conditions in the ERISA plan, was not preempted.
>
> In *Miller*, the Court read the second prong to apply whenever a law "alters the scope of permissible bargains between insurers and insureds." Directive 175 certainly alters the permissible bargains between insures and insureds by telling them what bargains are acceptable. Accordingly, the Directive affects "risk pooling" and is therefore saved from Section 514 (Section 1144) preemption.

But even assuming that Directive 175 is a state law directed to entities engaged in the insurance business (and there is no evidence that this is the case,

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[31] *Id.* at 342.

considering that it is directed only at ***health*** insurers, not insurers as a whole), there is no evidence in the record concerning the extent to which it affects risk pooling. Moreover, even if evidence was not required to support a determination about the effect of Directive 175 on risk pooling, the lower court's ruling was in error as a matter of law. In *Baxter v. Lynn*,[32] the Eighth Circuit analyzed the applicability of the savings clause to state subrogation laws and concluded that:

> The practice of subrogation does not transfer the risk from a policyholder to his or her insurer. Rather it limits the recovery available to the policyholder by preventing a double recovery.[33]

The critical point here is that subrogation does not transfer or substantially affect ***the risk insured against***.[34] In the context of a health benefit plan, the

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[32] 886 F.2d 182, 186 (8th Cir. 1989).

[33] *Id.* Although *Baxter* was decided under the test used by this Court prior to *Miller*, that test (based on the so-called McCarran-Ferguson factors) focused on "whether the law has the effect of transferring or spreading a policyholder's risk," and the only difference between the two is that the prior test "asked whether the statute in question 'transfers or spreads the risk from the insured to insurer.'" *Provident Life & Accid. Ins. Co. v. Sharpless*, 364 F.3d 634, 640 (5th Cir. 2004). In the context of this case, the difference between the two tests is not significant.

[34] *See Kidneigh v. Unum Life Ins. Co.*, 345 F.3d 1182, 1187 (10th Cir. 2003) (recognizing that the risk at issue is "the risk borne by insurers and the insured"), *cert. denied*, 540 U.S. 1184 (2004).

"risk" is the risk that a plan beneficiary may become injured, and will need medical treatment; the ERISA plan contractually agrees to pay for that treatment. The benefit terms of the ERISA plan define the scope of the plan's acceptance of that risk — a plan may, for example, provide for 100% coverage, for a lesser percentage, for a certain copayment, or for a wide variety of different terms that modify the risk. But, essentially, the plan accepts some or all of the risk that the beneficiary will need medical treatment for which someone has to pay. The Eighth Circuit correctly held in *Baxter* that antisubrogation laws only impact the risk of "double recovery" (an insured's ability to recover for expenses that it did not incur), which "bears no relation to the risk insured against" even though it "may raise the premiums paid for coverage."[35]

Unlike benefit mandates or any-willing-provider statutes, antisubrogation provisions do not increase the probability that the insured will be able to access covered services. Antisubrogation provisions only impact disputes that arise long after coverage has been provided. To be sure, Directive 175 affects the relationship between the beneficiary and the plan, but no matter what may happen in the subrogation arena, the beneficiary's medical providers will be paid, and there is no risk the beneficiary will not be able to obtain medical treatment because he or she cannot pay for it. At most, Directive 175 addresses the remedial issue of who bears the risk that, if a suit is ever commenced against a third party tortfeasor, there will be an

[35] *Nguyen v. Healthguard of Lancaster, Inc.*, 282 F.Supp.2d 296, 306 (E.D. Pa. 2003) (holding that Pennsylvania's Insurance Bad Faith statute did not fall within the savings clause).

insufficient pool of money available. But this occurs long after the beneficiary's medical bills have been paid; this kind of remedial provision does not affect the bargain struck between the beneficiary and the plan for the plan to pay the beneficiary's expenses.

B. Even if Directive 175 were not preempted, it would be invalid as a matter of federal law because it is an improperly issued state regulation purporting to supply a rule of decision for ERISA plans.

Even if Directive 175 were not preempted by ERISA's twin preemption provisions, the Fifth Circuit erred by failing to address whether Directive 175 is invalid as a state regulation that supplies a federal rule of decision. Despite the Commissioner's idiosyncratic views, Directive 175 does not accurately reflect Louisiana law, and should not be applied to a federal ERISA plan.

The Fifth Circuit avoided substantive consideration of this issue by finding that it was raised for the first time in Benefit Recovery's motion to alter or amend in the district court after summary judgment had been rendered against it. This was error. In point of fact, Benefit Recovery had always argued that Directive 175 was an invalidly issued state regulation, and the reply memorandum simply expanded on this argument by arguing that, as an invalidly issued state regulation, it could not be valid as a federal rule of decision. As noted above, the only argument presented to the district court on summary judgment was that of preemption under § 1144. By dismissing *sub silentio* Benefit Recovery's attack on the substantive underpinnings of Directive

175, the district court erred; and by refusing to consider the substantive merits of this argument, the Fifth Circuit erred as well.

Because Directive 175 purports to limit rights under ERISA plans, its interpretation and validity is a federal issue. In *Unum Life Ins. Co. v. Ward*,[36] this Court addressed the California state "notice prejudice" rule, which provided that an insurance company could not deny benefits on the basis of a late notice of a claim unless it proved actual prejudice. The defendant insurer argued that ERISA preempted "any action for plan benefits brought under state rules such as notice-prejudice." The Court determined that the state notice-prejudice rule supplied "the relevant rule of decision" under ERISA.[37] So too in this case does Directive 175, if valid, supply the relevant rule of decision under federal law,[38] and the lower courts should have examined whether, as a matter of federal law, Directive 175 could validly limit an ERISA plan's rights.

Had the Fifth Circuit examined the validity of Directive 175 as a matter of surrogate federal law, it would have readily seen that Directive 175 was issued without any legal authority. Directive 175 contains amorphous and mysterious references to Louisiana

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[36] 526 U.S. 358 (1999).

[37] *Id.* at 377.

[38] *Fink v. Dakotacare*, 324 F.3d 685, 689 (8th Cir. 2003); *Sutherland v. United States Life Ins.*, 263 F. Supp. 2d 1065, 1074 (E.D. La. 2003).

public policy, but nowhere bothers to identify how the Commissioner concluded that Louisiana governing law required the use of the make-whole doctrine or required an ERISA plan to share in the beneficiary's attorney fees. The Commissioner, despite his self-importance, is not the Louisiana legislature, and the law is not what he simply directs that it is. More is needed to effectuate the wide-ranging and immensely significant change he has wrought in Louisiana insurance law.

Conclusion

ERISA can be a frustrating statute to understand and apply. But if its preemption provisions mean anything, they stand for the proposition that a state insurance commissioner cannot dictate terms to an ERISA plan by forcing those terms to be included in the plan documents when the state legislature itself could not even accomplish the same result by positive legislation. Had Louisiana, by law, tried to make ERISA plans include the make-whole and attorney-fee-payment provisions of Directive 175, its law would have been preempted under a long line of precedent from this Court. The commissioner cannot be permitted slyly to do the very same thing through the expediency of the prerogative of his office, but if the Fifth Circuit's decision is left uncorrected, every insurance commissioner will be able to circumvent ERISA in the same way. Accordingly, Benefit Recovery respectfully prays that this Court grant its petition for certiorari.

Respectfully submitted,

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